IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is guilty of a Class A misdemeanor.	**Notification of Delegated Prescriptive Authority**	**PHA-CS**

A physician assistant controlled substances license is required if a collaborating physician is delegating limited prescriptive authority for controlled substances categorized as Schedule II, III, IV or V, as defined in the Illinois Controlled Substances Act. The collaborating physician must submit a NOTICE OF WRITTEN COLLABORATIVE AGREEMENT and a NOTICE OF DELEGATED AUTHORITY FOR SCHEDULE CONTROLLED SUBSTANCES to the Department.

COLLABORATING PHYSICIAN: Complete this form as official notification that you are delegating limited prescriptive authority to the physician assistant named herein.

If a collaborative agreement or delegated prescriptive authority is terminated, the collaborating physician must notify the Department within 10 days of termination by completing the NOTICE OF TERMINATION OF COLLABORATION AND/OR DELEGATED AUTHORITY (PHYSICIAN ASSISTANT).

Completed forms may be Emailed to: **FPR.MedicalUnit@illinois.gov**; Faxed to 217-524-2169; or Mailed to: IDFPR - Division of Professional Regulation, 320 West Washington Street, 3rd Floor, Springfield, IL 62786.

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at **www.idfpr.illinois.gov** to ensure you are using the current forms. **Please allow 4-6 weeks for processing of new applications and changes in collaboration and/or delegation**.

1. NAME OF PHYSICIAN ASSISTANT (Last, First, Middle Initial)	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. HOME ADDRESS STREET, CITY, STATE, ZIP CODE	5. **Physician Assistant Mid-level Practitioner Controlled Substances License** **3 8 5** Profession Name Profession Code	
6. HOME/CELL TELEPHONE NUMBER	7. LICENSE NUMBERS OF PHYSICIAN ASSISTANT **085 -** **385 -**	

This is to certify that I am a collaborating physician and have delegated limited prescriptive authority to physician assistant, _____, to prescribe and/or dispense prescription drugs, including controlled substances
(Printed name of physician assistant)
categorized as Schedule II, III, IV, V, as defined in the Illinois Controlled Substances Act. The physician assistant named above may prescribe and/or dispense prescription drugs and the controlled substances Schedules marked below.

I further certify the delegation of prescriptive authority is appropriate to my practice and within the scope of the physician assistant's training. The delegated prescriptive authority guidelines will be outlined and maintained, in the physician assistant's written collaborative agreement.

Schedule II*	☐ **YES**	☐ **NO**	**Schedule III**	☐ **YES**	☐ **NO**
Schedule IV	☐ **YES**	☐ **NO**	**Schedule V**	☐ **YES**	☐ **NO**

Such delegation of Schedule II shall be in accordance with the provisions set forth in Section 303.05 a)1)B) of the Illinois Controlled Substances Act

_____ Printed Name of Collaborating Physician	**036-** **336-** **ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN:**
_____ Signature of Collaborating Physician	_____ Fax
_____ Date of Delegated Prescriptive Authority	_____ Email

***SCHEDULE AUTHORITY IS NOT EFFECTIVE UNTIL THE LICENSE IS ISSUED.**